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THE PHYSICIAN AND THE PROBLEM OF ALCOHOLISM*

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WHAT I shall have to say this afternoon on alcoholism is directed not at all to the specialist treating this disease but to the non-specialist, the physician who meets the alcoholic and his family as incidental to his practice of medicine. The practitioner cannot usually be expected to treat the alcohol habit competently, nor would he, as a rule, wish to attempt this treatment. But nevertheless the part he plays toward the success or failure of eventual recovery of the alcoholic is often the crucial part. It is to the physician that the problems of the alcoholic and his family are usually brought first. It is the attitude of the physician which, in great measure, determines the course which the alcoholic will follow and also the understanding and coöperation—or lack of them—which the alcoholic and his family will show. A great many former alcoholics, who today occupy important and respected positions in our society, owe their eventual rehabilitation to the competent primary guidance of their physicians. There are, I am sorry to say, many, probably a great many more alcoholics who did not receive good primary guidance and for whom their physicians were not aids but actual, and sometimes insurmountable, obstacles to recovery. We

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usually think of that basic Hippocratic aphorism of our profession, *prima non nocere*—first do no harm—as applying only to misuse of drug and knife, but in respect to alcoholism the misuse of word and attitude may be equally harmful.

I shall devote much of my talk to this matter of the attitude of the physician toward the alcoholic and the influence of this attitude upon the treatment for alcoholism. But first, I want to try to clarify a common misunderstanding which has frequently influenced the scientific if not the personal attitude of the physician toward the alcoholic and his problem. It is the misconception of alcoholic as contrasted to alcoholism; one concerns the man and the other his habit. I have said that the non-specialist practitioner cannot usually be expected to treat alcoholism; he can, however, most competently treat the alcoholic. This is not a quibble in terminology; there is a vast difference between the two which is frequently overlooked. The treatment of the alcoholic consists in sobering up the man, giving him some symptomatic relief, determining and remedying his physical disturbances, correcting his dietary deficiencies, keeping him under good medical and hygienic care until some measure of normal physical health is restored. Unfortunately, some physicians, and even some institutions, consider this an ultimate treatment. Under their care the alcoholic, in a week or a month, may show marked physical improvement; he may even stop drinking for another week or another month but in the great majority of instances he starts his heavy drinking again. This relapse and a second, a third, a fourth and a fifth, each following a period of treatment of the alcoholic, are discouraging. It leads to pessimism not only as to the expectation of more than temporary benefits of physical rehabilitation but also, and more important, as to the probability of any recovery from alcoholism. The pessimism shows in the attitude of the physician toward the alcoholic; it is sensed acutely by him to the detriment of any subsequent therapeutic success.

Actually the pessimism is not justified. It is not surprising or discouraging that a habit persists when treatment is not directed to the habit but only to the physical derangements which are results and not causes of the habit.

Again, the pessimism of the physician may originate in or be reinforced by two undeniable facts which seem discouraging in their baldest statement but which are far from discouraging in their interpreta-

tion. The first is that alcoholism cannot be cured. That, today, in the great majority of instances, is scientifically correct. But it is correct only if the physician will insist upon the same rigid definition and use of the word "cure" when applied to other diseases. There is no specific for alcoholism as there is for syphilis. Likewise, there is none for tuberculosis and typhoid fever, but this lack does not impart a corresponding pessimism as to a possible recovery. The fact that there is no cure, in the strictest sense of the word, for these diseases does not deter the physician from applying every measure which will give the greatest opportunity for recovery. We are prone to forget that the tremendous advancement of medicine which arouses our enthusiasm has by no means taken all of the truth from the modest words—now 400 years old—of Paré: "I treated him; God healed him." Or perhaps you might prefer to say it impersonally, but with equal medical humility and understanding: "He got well under treatment."

The second undeniable fact is that recovery from alcoholism nearly always means only that the former alcoholic has ceased to drink and, of course, has become rehabilitated. It rarely means that he has regained or obtained what might be called a normal reaction to the use of alcohol. The compulsion to drink excessively is not eradicated, it is simply brought under control and it is held under control but only as long as no alcohol is taken. One drink, and the compulsion may again dominate. Recovery from the habit is usually a symptomatic recovery only.

These two facts must be recognized and they must be faced not only by the patient but also by his physician. They are not discouraging facts that can be construed to give to the physician—and through him to the patient—the obstacle of disbelief in recovery. The important fact is that with proper guidance a high percentage of alcoholics can learn to control their habit and become rehabilitated. And most of them are—even aside from any humanitarian consideration—well worth rehabilitating.

There are many forms of treatment for alcoholism and, for all, recoveries are claimed and no doubt obtained. Multitherapy always arouses suspicion in the mind of the physician, for from experience he knows that any malady which has many treatments has no good one. But the assumption that because there are many treatments with recoveries from alcoholism, none is valid must rest upon *a priori* assumption that the excessive use of alcohol, the determining symptom,

has always a common etiology. I do not think that it can be shown that there is a common etiology for excessive drinking.

Such a statement implies disbelief in physical, chemical, or pharmacological idiosyncrasy as the basis upon which excessive drinking rests. The discovery of such a basis, if one could ever be made, would hold out great promise not only for the pharmacological cure of alcoholism but also for the more important prevention by the designation, from tests, of those who were susceptible to alcoholism and therefore must never drink. The psychiatrist, from his inability to find a definite prealcoholic type of personality, is prone at times to pass the matter back to the physiologist and pharmacologist. It is true that he raises pertinent questions, such as these: Some men with manic depressive psychosis drink to excess, especially periodically, but others with this psychosis do not. Why, when alcohol is universally available and widely experienced, do some find a partial symptomatic relief in drinking and others do not? The same applies to the early schizophrenic. Some become violent symptomatic drinkers; others do not drink at all. Among alcoholics there appears to be a large number of psychoneurotics; but there is a vastly larger number of psychoneurotics of equal or even greater involvement who, with like opportunity, do not drink to excess. Such facts as these quite naturally suggest the possibility of a somatic common denominator acting among those who turn to alcohol. None which is valid has ever been found, and in the extensive physiological studies dealing with the action of alcohol none has ever been soundly indicated.

One especial feature characterizing the drinking behavior of many alcoholics has led some authors to the postulation of an allergic-like reaction to alcohol which, by them, is taken as a common denominating somatic factor. This so-called allergy has as its major manifestation not the usual allergic reactions, but instead, uncontrollable drinking after a drink is taken. That is, the alcoholic can become abstinent and can remain so but he cannot become moderate in his use of alcohol. His action is none, or all.

The conception of an allergic-like response to alcohol has had a measure of recent popularity because it is particularly acceptable to the alcoholic: First, in view of the wide popular interest in allergies for foods and pollens, the alcoholic can find an understandable explanation of why he must shun all alcohol; second, the allergy idea pro-

vides the alcoholic with an excuse which receives sympathetic understanding when he refuses a drink with the explanation that he is "allergic" to alcohol; and third, he is given an ego satisfaction, which he needs badly, in being physically rather than mentally or morally different from the majority of human beings and in having no volitional responsibility for this difference. The acute sufferer from asthma, hives and hay fever rarely appreciates the distinction conferred by his allergy, but the individual who, after taking one drink, invariably goes on a spree may find considerable comfort in the explanation that his behavior is due to an unfortunate body chemistry.

Now, as a matter of fact, when the literature is searched carefully to follow the rise of the concept of an allergic origin of craving it is found that with few exceptions the idea advanced has been mainly metaphorical. The actual term used has been "psychic allergy" or a "psychobiological sensitivity which is practically an allergy" which perhaps may be defined as a condition of exaggerated response in which the allergen is a mental or emotional state. It is doubtful if the readers of such statements—and certainly not the patient to whom they are repeated—note the qualifying term of psychic, psychic allergy, which removes the matter from somatic cellular reactions and restores it to mental reactions. The more familiar ideas of chemical allergy to foods and pollens tend to blind one to the qualification of "psychic allergy" and lead to the inference of a true chemical allergy to alcohol for which there is no scientific basis.

The attempt to express alcoholism in terms of allergy is not surprising in light of the long history of the effort to find a pharmacological basis. Similar attempt has been made to attach the basis of alcoholism to many medical discoveries which have attracted wide popular interest. Thus, near the end of the last century attempts were made to prepare an immunizing serum from gradually alcoholized horses. Toxic states, gouty impurities, and endocrine disturbances have all been advanced as causes. Such attempts have not failed because they advanced a single etiology or a somatic etiology, but because they advanced false etiologies.

The lack of a defined common etiology means that the practitioner, in dealing with his alcoholic patient, must make some differentiations if he is to direct his patient to the most advantageous therapy—the one best suited to the alcoholic. At this early stage there comes an im-

portant qualification; it is the one of economics. If the patient can afford possibly long and necessarily expensive care, the diagnosis and full responsibility for therapy and rehabilitation can be shifted to one of the competently staffed private institutions treating alcoholism (in contrast to those treating only the alcoholic as I developed earlier). In many, perhaps the majority of instances, the alcoholic cannot afford this care. The responsibility of obtaining the most advantageous therapy that the patient can afford then rests upon the physician. The selection of the therapy involves preliminary diagnostic study but of a sort that requires no extensive psychiatric sophistication. The questions before the physician are: First, is this patient an alcoholic? And second, if so, what general sort of alcoholic is he?

The first question enters only occasionally. Usually the history of the individual leaves little doubt that he is drinking in great excess but occasionally there is doubt. Once in a while an individual who is distinctly hypochrondriacal will volunteer the statement that he fears alcohol is getting the better of him and that he is becoming an alcoholic. More often perhaps the wife or the mother comes to the practitioner with the statement—based often on a complete lack of sophistication or, more likely, on strong anti-alcohol convictions—that her husband or son is an alcoholic. Such statements are frequently expressions of a losing part in an argument on the question of any use of alcohol, in which reinforcement from the physician is sought.

The presumed alcoholic, brought or forced to the physician by a member of his family is, as a rule, not in a favorable situation for that rapport between the physician and patient which is necessary for the successful treatment of alcoholism. Somewhat more favorably situated is the patient who is under treatment for some somatic complaint and in whom the physician discovers the probability of alcoholism. Both such patients may stoutly deny that they are alcoholics. It would seem undesirable that the physician make his decision wholly on the basis of the amount of alcohol consumed per day unless that amount is so large as to be unmistakably excessive even under the most liberal standards. I have heard physicians discuss the matter of amounts of drinking that indicate alcoholism and these amounts vary only with the physician's personal convictions and habits and hopes. Thus I have heard physicians say that they considered as an alcoholic anyone who daily drank two glasses of beer or two ounces of whisky; and I have

heard others dismiss with a shrug the drinking of a pint or more of whisky a day, over a long period of time.

Again, it may be well to remember that in stating amounts consumed daily, both the alcoholic and his family are often biased and consciously or unconsciously over- or under-estimate. One of the best tests for many, but not all, alcoholics is not in amount, not in asking the possible alcoholic to see if he can abstain entirely—for many can—but to limit his drinking for a time strictly to two drinks a day. That, most cannot do. And the fact that he cannot, may, for the first time, bring home to the patient the fact that he is actually an alcoholic and does not have the control over his habit which he believed he had.

Having established the fact, or presumption, that the patient is an alcoholic, the next diagnostic measure—barring the physical examination—would be to make an evaluation as to what sort of alcoholic the patient is. There are numerous and elaborate classifications but a convenient and sufficient, but quite arbitrary one, for the general purposes with which I deal is: (1) symptomatic drinking; (2) true addiction; and (3) secondary addiction. The distinctions are, as I say, arbitrary and open to psychiatric argument which I certainly would not attempt to defend. But for the purposes here, I think it may be taken that the symptomatic drinker is a man whose excessive drinking is one of many possible symptoms of some deep-seated disturbance—possibly a psychosis. Some diagnostic guidance may be had from the nature of the drinking. If it is periodic, perhaps at intervals of several months, with abstemious periods, the possibility of a manic depressive psychosis in which the patient drinks in either the manic or depressive stage may suggest itself; likewise suggested may be epileptic states; and occasionally severe endocrine dysfunction. If symptomatic drinking is steady, wild and witless, the possibility of early schizophrenia (especially if the patient is young) or early general paresis, may be suggested. Recovery from alcoholism under any form of treatment directed only at the alcoholism is useless in the symptomatic drinker. Psychotherapy, aversion therapy, or counselling by Alcoholics Anonymous would lead only to failure with the possible reinforcement of the pessimistic idea that treatment for alcoholism is hopeless. Thorough psychiatric examination is indicated before any time is wasted in treating the habit of the symptomatic drinker.

In most classifications, a distinction is made between so-called true

addicts and secondary addicts. The distinction is mainly that of degree of psychopathology inherent in the drinker before he started drinking. The true addicts have a profound but non-psychotic maladjustment; they are the most dramatic and the most pitiful of the excessive drinkers but fortunately, at present, the smallest group. I put in the qualification of "at present," for a profound and widespread alteration of social and economic conditions may lower the level at which maladjustment of personality is manifest. The true addicts make up the group that occupies a prominent position in popular and medical views, because they express to the highest degree the general conception of the true alcoholics—the men to whom alcohol is a complete solution to the problem of adjustment. They do not respond well to treatment, but they are not entirely hopeless, for if they can be shown and convinced that their conflicts can be relieved by means other than alcohol, they may develop more acceptable behavior. They, again, are not the type of alcoholics for whom the aversion treatment or the counselling of the Alcoholics Anonymous, or any treatment on a similar plane, would be likely of success. They are the problems, and the difficult problems, for the psychotherapist in the broadest use of this term.

So far, I have tried to differentiate two broad classes—I might say exclude them—on the basis of maladjustment so severe that abolition only of the symptoms of excessive drinking and rehabilitation would yield an individual who was still unable to make adjustments even approaching the normal. After this exclusion, there is left a very large number of alçoholics whose prealcoholic psychopathology falls within that wide and indefinite range for individuals who could make reasonably normal adjustments. They were not, before their alcoholism developed, severe psychoneurotics; they are men whose drinking habits have become abnormal under the influence of predominantly exogenous factors—including alcohol itself.

No prealcoholic personality type has been differentiated for this large group of alcoholics to which I have reference here. Possibly searching psychiatric examination might indicate certain tendencies but as yet none has been found which is sufficient for the selection, with any certainty, of potential alcoholics of this group. After the alcoholism has become well developed, however, certain general personality or character traits seem to appear, to be superimposed or possibly uncovered. They are certainly not to be taken as diagnostic criteria, for

they may be found in many non-alcoholics, but they do serve in a measure as a fairly common factor among alcoholics. The importance of this factor lies in the fact that it gives some understanding of the behavior of the alcoholic. It therefore indicates an approach to dealing with the alcoholic; it indicates the attitude of the physician particularly toward establishing that rapport which is the first and most essential feature toward any successful therapy for the alcoholism of the so-called secondary addict.

It is not within my competence, nor is it of practical interest to the practitioner, to attempt any analysis of the basic forces operating to bring about the changes in the personality or character of the alcoholic. It is the clinical pictures only in which I am interested here. In its exhibition the change is one toward the essential egocentricity that so strongly characterizes the child. The alcoholic may be thought of as a child and may best be handled as a child. An appearance of grave respect, deep understanding, and broad tolerance with no recriminations, illicits confidence from the child—and from the alcoholic.

The development of the apparent retrogressive change in personality or character of the alcoholic is often slow. In the early stages of excessive drinking it is difficult to detect the beginning alcoholic from the occasional heavy drinkers who do not become alcoholics. In the face of difficulties the incipient alcoholic tends, perhaps, to drink more often than his associates and his drinking is more likely to reach the stage of drunkenness. As he drinks more, he develops a greater psychological tolerance to alcohol and large amounts may be required to give gratification. Eventually, as a possible turning point, he goes on his first spree of completely uncontrolled drinking. At first, sprees may be only occasional, but they tend to become more frequent, to occur from less and less provocation and to last longer. Gradually a compulsion to drink is developed; a spree tends to follow any drinking but periods of abstinence may still occur between sprees. At this stage, after the spree, a deflated feeling is experienced; the enthusiasm and exuberance which were carried into earlier sprees and the vigor which was carried out of them is lacking. The alcoholic is tired, guilty, contrite, and, in his remorse, makes vows. But with the first subsequent drink, all responsibility to vows is disregarded. And preliminary to that drink, there is frequently a fairly definite prodromal syndrome. A psychic tension develops; the alcoholic is irritable, cranky, sour,

restless and jittery. Only a drink will relieve this tension—and a drink means a spree.

At this stage there is usually evidence of a type of thinking that shows, undisguised, the alcoholic's juvenile egocentricity. He feels omnipotent but insecure. He demands, and expects, that he shall be the center of interest. He is sorry for himself and interprets even the most reasonable demands as thwarting him. He wants to dominate. He objects to routine and restraint. His attitude may anticipate thwarting and be hostile, cynical, defiant. At the same time he may exhibit for art, or beauty, or music, enthusiasms that are as exaggerated and unguided as those of a "bobby sock" crooner fan. He senses a loneliness and isolation, a feeling of being apart and of the impossibility of being close to others. To this he may over-react into complete isolation or, in contrast, to a fawning effort to ingratiate. He promises to do better—he has learned his lesson—but his words carry only the responsibility of those of the temporarily frightened and contrite spoiled child. In degrees greater or less, exhibited through the superficialities of a culture which is polished or crude, this is the patient with whom the practitioner must deal.

If the attitude of the physician is understanding, tolerant, patient, serious, he may win the confidence of his patient and be able to help him. Recriminations are useless, for the alcoholic has deep within him the strongest feelings of guilt and responds to them with hostility. They are only further proof that no one understands him. A high moral tone, preaching, drives him away. The gift of really understanding the alcoholic, winning his confidence and coöperation, is often held in high degree by ex-alcoholics who act as lay therapists or group therapists as in Alcoholics Anonymous. They have been through the same experience themselves; they know the feeling of tension, of discontent, of omnipotence, of guilt, and of resentment. They know, and forgive, the inevitable "slips;" after the spree, they are able to maintain their fully understanding attitude and an unabated confidence. The physician, to be succesful, must maintain the same confidence.

There is no group of individuals—except children—who are more responsive to the attitude of the physician and sense his sincerity or lack of it more acutely than do alcoholics. And, as I said in the beginning of this talk, it is the attitude of the physician and his depth

of understanding which may be the deciding factor in the recovery of the alcoholic; if he understands him and if he can make the members of the family and business associates likewise understand and cooperate, he has a good chance of steering the alcoholic toward recovery. Contrariwise, an adverse attitude, whatever its reason, may be, and may remain, the insurmountable obstacle to recovery.

I have also mentioned earlier that there are many different therapies of alcoholism. They are seemingly widely divergent in nature, but they have one element in common. It is the essential conviction of the possibility of recovery. The alcoholic will rarely recover under any treatment unless he believes he can recover and he wants to recover. One might go even further and say that if he can be so inspired to believe in recovery, he will recover under almost any kind of treatment if his confidence is carried over to the treatment and identified with it. It is, I think, the major function of the practitioner to inspire the desire and confidence and then select, at the necessary economic level, a therapy which he believes will be most suited to hold the respect of the patient.

In a recent article, Dr. Abraham Myerson has summed up the essential approach to successful therapy and also gives expression to a somewhat pessimistic view as to the specific virtue of any one particular method of treatment. He says: "The one common factor of all the therapeutics of alcohol addiction is embodied in the statement which is made by all therapists. *The patient must have the desire to be treated. He must wish to get well. He must be willing to cooperate.*" To these factors I should add the one which I have just discussed and which I think is equally important: *He must believe that he can get well.* Again, in this last respect the lay therapist who is an ex-alcoholic has a particular advantage; he not only speaks the alcoholic's language and knows his feelings, but he has been through it all himself and is there as a tangible example of the possibility of recovery.

In creating the will to recover, it is usually essential to bear continually in mind the predominantly egocentric attitude of the alcoholic. The reason for recovery had best be made to stem from his own self-interests, his own ego, and not from family neglect and failure of duties which are topics prone to arouse undesirable emotional reactions. Something of this reaction, but in a most desirable direction, can sometimes be transferred to the alcohol itself by bringing it into

competition with his ego. He may believe, or pretend to believe, that he has control over his drinking; he is the master. If he can be made to see, and made to realize that others also see, that in reality he is not the master, that, in spite of his claimed omnipotence, he is the servant, his egocentricity may be turned to advantage as resentment against the alcohol, or as a fear of it. Again, a serious and dispassionate explanation by the physician of the probability of fairly rapid somatic deterioration as incidental to his heavy drinking, may arouse sufficient fear and yet provide an acceptable excuse for the desire to stop drinking.

Dr. Myerson, after stating the essential prerequisites to any successful therapy that I have given above, expands, as I have said, upon his doubts as to the specificity of any particular method. He says: "It may be that whatever method is used, if this will is present, if the desire to be free of alcohol addiction has reached that point of burning heat which James calls 'conversion,' it does not matter much whether benzedrine sulfate, which makes one feel good, or wine of ipecac, which makes one vomit, is utilized; it is of relatively little importance whether an exhorter does the trick by firing zeal through the fear of God or the friendly greeter of Alcoholics Anonymous is the agent of reform. The alkaloid strychnine will work as well, and no better, than the hormone insulin. In other words, the essential of all these therapeutic measures seems to be to enlist the cooperation of the patient, to galvanize his will, to bring about his conversion rather than to use any one specific measure."

What Dr. Myerson, as a psychiatrist, is saying, if I might rephrase his words in these possibly blunter ones of a physiologist, is: the therapy of alcoholism is faith healing. The same, with equal bluntness, might be said of a good deal of psychotherapy. But even if it be true, I see no implication of belittlement. Physicians are prone to give a bad name to the whole conception of faith healing because they have come to regard this term in derogation from the early and even modern misapplication of this therapy to somatic diseases. Certainly the treatment of tuberculosis and broken legs by the laying on of hands and prayer deserves derision. But I do not think this derision should be inherent in the term "faith healing" when applied to the alteration of behavior habits. I doubt extremely whether faith has ever moved any mountains, but I know beyond doubt that it has moved

and is moving whole nations of men into patterns of behavior, into habits for the maintenance of which they are willing to die. I see nothing to be ashamed of in the statement that much of the therapy of alcoholism is faith healing and interpreting the rapport established between the patient and therapist as a feature common to all faith healing. All that these statements signify is that there is no specific somatic–pharmacologic–therapy for alcoholism. The important fact is that a great many alcoholics can be helped to recovery and to full rehabilitation.

While I am not wholly in agreement, let us for the moment, to avoid argument, accept the baldest interpretation of the therapies as faith healing. And you will remember that I have excluded from the handling of alcoholism those alcoholics who are symptomatic–psychotic–drinkers and those with extensive prealcoholic psychopathology. The alcoholics to whom I am attempting to direct the attention of non-specialist practitioners are those of that group who, when their alcoholism is cured, their prealcoholic health and character restored, are, within a broad interpretation of the term, reasonably normal human beings. They constitute the largest group of alcoholics and the majority cannot afford a long period of institutional care but must be treated, so to speak, as ambulatory. We shall assume further that the practitioner has met them with a helpful attitude and carried out, with some success, his vitally important function of establishing the preliminary attitude toward treatment. The patient is thus prepared for the therapy of his alcoholism. The selection of the therapy falls upon the physician. I have assumed, wholly for our argument, that the therapy is faith healing but a common designation does not mean that all forms which the healing may take are equally suited to the particular patient. The therapy selected must be one that suits the patient, one that he can believe in and will respect.

The practitioner may decide that his patient will react best to the group fellowship of Alcoholics Anonymous; that he can be touched by proffered understanding and by actual aid in his "slips," and that he can be aroused to a deep desire and responsibility to help others. If so, the necessary contact should be made. If, on the other hand, the physician feels that his patient does not have these qualities–perhaps a trifle sentimental in nature–he might turn to the one method best suited to the patient to whom a rational medical explanation would

make the strongest appeal, the so-called aversion or conditioned-reflex treatment. This method, which consists in the attempt to arouse an actual distaste for alcoholic beverages by the association of their taste with nausea and vomiting, possibly has a sounder physiological basis than faith healing only, but for it, the preliminary rapport is necessary; during it, a certain amount of suggestions; and after it, periods of reinforcement. If this forthright therapy, which perhaps makes its greatest appeal to the practical and hard-headed patient, seems also unsuited, there remains the individual, more expensive, and longer help of the psychotherapist who should be selected not only for his interest in alcoholism, but also for his personality.

At the danger of being unwarrantedly repetitious, I want to say again that the most essential step in any therapy of alcoholism is the initial contact—the part played by the practitioner. When his approach to the alcoholic is understanding and tolerant, something of the rapport is established; and when the practitioner is willing to listen, to advise, to talk to the family and help straighten out social difficulties, to be on the alcoholic's side, to guide him but not be exploited by him, he is himself carrying out the soundest and most helpful therapy of the alcoholism itself.

I have spent much time on what I have repeatedly called the physician's attitude and in so doing I have particularized. Now I want to generalize, to consider what forces have shaped the attitudes of the physician and too often shaped them to the detriment of the alcoholic. There is sometimes a tendency on the part of the members of our profession to feel that we are not only the inspirers for any broad social changes with medical implications but also the leaders who bring them into being. Sometimes I am led to wonder if this belief is justified. We all are products of the society in which we grow up; our fundamental views and beliefs on social matters, even those with medical implications are, I suspect, most often determined before we go into medicine. It is a chastening reflection that some of the greatest humanitarian social reforms built out of the potentialities of medicine were not seen or pioneered or led to social application by the physician. Sometimes they have even been obstructed by him. Often his attitude has been as bigoted as that of his non-medical neighbors.

I might illustrate this unfortunate fact with the rise and growth, a century ago, of an idea which is very pertinent to that held today

regarding alcoholism. You will recall that about a century and a half ago, Dr. Phillipe Pinel advanced the idea that the symptoms of insanity might be ameliorated by humane care. To him, humane care meant the removal of manacles and chains and the discontinuance of torture. This therapeutic experiment aroused little interest among physicians. Half a century after his time there was no publicly supported institution in the United States for the care of the chronic insane. And, what was even more important, insanity was not considered by the physician as a disease in the sense that typhoid and smallpox were diseases. Insanity was felt to have in it a large element of plain human weakness, meanness and immorality—it was misbehavior for which the patient was, in some measure, responsible. The laws of the period made perhaps a better distinction as to responsibility than did the public and the physician. The physician, by and large, in dealing with the insane showed his impatience, his disgust, his dislike; he showed complete lack of understanding and sympathy. Probably he did not personally whip his patient, or throw cold water on him, or chain him in a cellar, but he directed and saw these things done. The deep sympathy and compassion that the physician had for the somatically ill did not flow over to the mentally ill; like the rest of the public he could find a cruel humor for their symptoms.

Then, as you will recall, in the forties of the last century, a Boston school teacher, Dorothea Linde Dix, led the crusade that resulted not only in our tax-supported care of the chronic mentally ill, but in an entire change in public attitude. The concept of mental illness, carrying with it all the compassion formerly limited only to physical illness, became the new view of the public—and of the physician as part of that public.

Today, the physician, brought up in the mores of the earlier decades of this century, holds consciously or unconsciously many of what might be called pre-Dixian ideas in regard to alcoholism. And this view tends to be intensified by these features: First, the long preaching against the use of alcohol on the basis of morals; second, and quite opposite, the moderate and controlled personal use of alcohol by the physician; and third, the cruel attitude which sees in drunkenness on street, or stage, or radio, a subject of contempt or humor. The consequence is that the physician is sometimes prone to see the alcoholic as a man who deserves punishment—hence as in the

pre-Dixian days the drunk is usually a ward of the police court and his treatment a jail sentence and repeated sentences; he is prone to see the alcoholic as a man who cannot control a habit which in less degree he indulges in himself and therefore sees him in contempt for his weakness; he is prone to see the drunk as humorous or disgusting, and not as an ill man exposed to public derision but deserving sympathy and medical aid for the correction of his alcoholism; and last, he is a little prone, again sharing the public view, to believe that alcoholism is hopeless and the alcoholic not worth rehabilitating. It is such views, derived from the public of which the physician is a part, that have too frequently shaped the medical attitude toward alcoholism.

A fundamental social need today is in the development of the public opinion that alcoholism is a disease and that the alcoholic is an ill man deserving of the sympathy and care rightfully owing to an ill man. When public opinion—and in such matters public opinion often determines medical opinion—is so shaped, we will have made not only an humanitarian advancement but one of great practical importance toward the rehabilitation of the alcoholic and the prevention of alcoholism. Organized movements are already started which have among their purposes this shaping of public opinion, not in moral, but in medical and social channels, as part of the attack on alcoholism. Among these is our group and school at the Laboratory of Applied Physiology at Yale, with its affiliated National Committee for Education in Alcoholism; the Research Council on Problems of Alcohol; and the Committee on Alcohol Hygiene stemming from Johns Hopkins Medical School.

The problem of alcoholism is, even in its strictly medical implications, a large problem. Reliable statistics indicate that in the United States today there are some fifty-five million users of alcoholic beverages. The overwhelming majority of these men and women drink in a moderation that in no way endangers them. But some two million use these beverages to an extent that renders them liable to alcoholism. It is a small percentage perhaps, but it applies to a large number. Another half million have already become alcoholics to such a degree that they have impaired their physical and mental health. Any condition that threatens the health of two million people, and has already seriously affected the health of a half million, is a public health problem of important magnitude and one deserving the respect of the physician.